J. A. L. Gilbert

Alcoholic and Drug Addicted Physicians: The Scope of the Problem

SUMMARY

Alcoholism and drug addiction are occupational hazards in the practice of medicine. Reports from Canada, the U.S. and U.K. show a higher incidence of these problems in physicians than in the general population. This article reviews some characteristics of addicted doctors, including their backgrounds and reasons for starting the habit. The need for treatment to start as soon as the problem is discovered is emphasized. The prognosis for both alcoholism and drug addiction is good if the conditions are diagnosed early and treated vigorously. (Can Fam Physician 26:851-853, 1980).

Dr. Gilbert is director of the detoxification unit at Royal Alexandra Hospital in Edmonton, and a professor of medicine at the University of Alberta. Reprint requests to: Royal Alexandra Hospital, 10240 Kingsway, Edmonton, AB. T5H 3V9.

PHYSICIANS HAVE ALWAYS been associated with health. However, it has long been recognized that the practice of medicine carries certain health risks. In earlier times, tuberculosis was frequent amongst pathologists,[1] ionizing radiation took a toll of its pioneers[2] and a decade ago hepatitis was frequent in physicians working in renal dialysis units.[3] The association between the practice of medicine and the development of coronary artery disease is less clear.[4-6]

During the last 15 years there have been a number of studies on the mental health of physicians.[7-13] These reports—from the United Kingdom, the United States and Canada—show a disproportionately high incidence of alcoholism and drug addiction in physicians.

Alcoholism

Alcoholism is a long recognized health problem in Canada, where it is currently a leading cause of death, and along with suicide, one of the most rapidly increasing. It is estimated that alcohol is used by 70% of the U.S. adult population of whom some six to ten percent are alcoholics.[14] A U.S. study shows that the incidence among physicians may be as high as 18%.[15]

The precise cause of alcoholism remains unknown; genetic, sociological and psychological factors are probably all involved. Alcoholics conform to no specific personality type and vary from normal to frankly psychotic.

Murray,[16] who followed up alcoholic doctors treated in a London hospital, found that they had undergraduate records comparable to non-alcoholic physicians, varying from dismal failure to outstanding success. He also suggested that the alcohol habit may be started where there is a permissive attitude toward drinking or when masculinity is thought to be measured by the ability to hold liquor. In most instances the physicians started drinking heavily between the ages of 40-50, and attributed it to such factors as a need to relax, inability to sleep, overwork, and to increase sociability.

Connelly[17] noted two age peaks for alcoholism, as well as drug abuse in doctors: the first, between 30-40, before developing a successful medical practice. This group tended to have severe psychopathology. The second peak was at 50-65 years, *after* practice was well-established, but before midlife crises or depression developed.

The studies show a different incidence of alcoholism in various specialty groups: Murray found that of physicians admitted for psychiatric care, the highest incidence was amongst those in general practice and surgery, whereas Bissel and Jones[14] found psychiatrists and family practitioners had the highest incidence.

Physicians develop the same organic and social sequelae to their drinking as does the general population. They are in no way immune to potentially fatal central nervous system complications, alcoholic cardiomyopathy and cirrhosis of the liver, as well as suicide, which are given as the main reasons for the alcoholic's ten to 12 year reduction in life expectancy.[17, 18] They are also not free from impaired driving or broken marriages. Bissel and Jones[14] reported 219 arrests and 170 jailings amongst 98 alcoholic physicians they studied.

Drug Dependence

Drug dependence also seems to be an occupational hazard for physicians. The Medical Board of California believed that one to two percent of its members abused drugs, and as long ago as 1958 was dealing with 125 cases annually.[19] New York State quotes an incidence of 0.5% amongst its physicians compared with one in 3000 in the general population.[20, 21] Figures from the U.K., U.S., Holland and France suggest that 15% of all drug addicts are physicians.[19]

In a high percentage of cases it either precedes or is associated with alcoholic abuse. Narcotics, particularly morphine and meperidine, are the most frequently abused.[22, 23]

Physician addicts were often sickly as children, suffering from abdominal cramps or asthma, and seldom excelled or even took part in sports.[22] They report that their sex life is unsatisfactory. Their fathers were either passive or domineering, and 50% of them were alcoholics. Mothers were excessively neurotic, religious and sickly, as well as domineering in some cases. Eighty-five percent of them were said to have 'unusual' personalities.

The physician addict differs from the usual drug abuser. A study from Virginia[22] showed the mean age of the drug abusing physician is 40-45 and he has been in practice for 18 years. He has a good home and is married with a family. The precipitating factors most frequently mentioned include physical pain, usually from a chronic illness, death of a wife or child, and an addicted wife.

In contrast, the nonphysician addict is generally 19-30 years old, unmarried, poorly educated and a member of a minority group. Drug abuse is an end in itself and he steals to support his habit.

Management

Doctors feel somewhat frustrated in handling alcoholics, and particularly alcoholic colleagues, probably because of a lack of training. The curricula of most medical schools gives the impression that alcoholism is an uncommon disorder, scarcely worthy of curriculum time. I find it unusual that neither the Royal College of Physicians and Surgeons of Canada nor the American College of Physicians in the last ten years has seen fit to devote one postgraduate course specifically on the fourth leading cause of death on this continent.

How have we dealt with the physician we've known since his student days as a heavy drinker at cocktail parties and other social events? His work standards are now beginning to slip a little—nothing serious—but into general deterioration. Have we taken him aside and told him of our concern?

No. We've turned a blind eye, hoping the problem will go away or waiting until he makes a serious mistake with which we may confront him.

But at that point, he changes from being a friend and colleague to a fiend. We review his hospital work—it was a little substandard and find also that he really contributed little to committees. He is brought before the hospital board and dismissed. We feel a little uncomfortable, even guilty. After all, he is one of us and we have let him down.

The watchword should be immediacy. The prognosis for addicted physicians is good if the condition is diagnosed early and treated vigorously. Of the 41 doctors in Murray's study who had been drinking from six months to 25 years before treatment, many were severely alcoholic and nine suffered from delirium tremens.

Principles suggested for management of the alcoholic physician[24] can also be applied to the drug-addicted doctor:

1. At the first sign of continual heavy drinking, the physician must be warned by a colleague of its dangers. Few realize that daily consumption of more than 50 ml of ethanol puts them at risk. There must be no delay or waiting for further developments—a course of therapy and counselling, and membership in Alcoholics Anonymous should be started immediately.

2. If he commits a major offence such as appearing intoxicated in the operating room or while giving a lecture, he must be confronted immediately, suspended by the hospital board, and brought to the local college. He must not be treated as a criminal but as a friend and colleague who is in trouble. He should be given all the help available, both in his rehabilitation and preserving his practice. There is no place for a 'holier-than-thou' attitude. On the other hand, the greatest hazard to his recovery is granting him special patient status. He has a serious disease which will require psychiatric help.

3. He must not return to work until he is well. Addiction and medical practice do not mix.

4. Following his return to work, he will need to be under surveillance for two to three years by a physician willing to assume this responsibility. Some colleges use 'three wise men',[25] others appoint a single senior physician.

Society, including the police, has

been sympathetic towards the impaired physician, but it is apparent that the constabulary is increasingly less tolerant of his behavior than are his colleagues.[14] An increasing number of impaired physicians is being 'managed' by the law rather than by the profession.

Finally, no physician should ever write himself a prescription or give himself an injection which will either relieve severe pain or alter his mood. The solo practitioner in a rural setting is particularly vulnerable.

Prognosis

The prognosis for the alcoholic physician depends on a number of factors, not the least of which is the severity of his addiction and the support from his local community and peers. Goby, Bradley and Bespalec[26] recently quoted a figure of 67% recovery, which is rather better than my own experience but a realistic goal to be aimed for. The fate of those who fail to respond is well documented by Murray.[16] Of 36 physicians followed up for an average of 63 months, seven died—two suicides and two probable suicides—ten continued their drinking habits intermittently and nine continued dependent drinking. Five were totally abstemious, two became normal social drinkers and 17 required further inpatient psychiatric care. Of the 29 alive, only eight were practicing, six with varying degrees of incompetence, three had retired voluntarily, two retired under compulsion, and the names of four did not appear in the subsequent issue of the medical registry.

Drug addiction shows comparable variability, with success quoted as 27-72%.[22, 27, 28] These depressing statistics make the need for early diagnosis and treatment more important. ◉

References

1. *Reid DD: Incidence of tuberculosis among workers in medical laboratories. Br Med J 1957; 2:10-14.*
2. *Court-Brown WM, Doll R: Expectations of life and mortality from cancer among British radiologists. Br Med J 1958; 2:181-187.*
3. *Drukker W, Schouten WAG, Alberts CHR: Report on regular dialysis treatment in Europe. Proc Eur Dial Transplant Assoc 1968; 5:3-11.*
4. *Emerson H, Hughes HE: Death rates of white male physicians in the United States by age and cause. Am J Public Health 1926; 16:1088-1093.*
5. *Dickinson FG, Martin LW: Physician mortality, 1949-51. JAMA 1956; 162:1462-1468.*
6. *Doll R, Peto R: Mortality in relation to smoking: Twenty years' observation on male British doctors. Br Med J 1976; 2:1525-1536.*
7. *Duffy JC, Litin EM: Psychiatric morbidity of physicians. JAMA 1964; 189:989-992.*
8. *a'Brook MF, Hailstone JD, McLaughlin IE: Psychiatric illness in the medical profession. Br J Psychiatry 1967; 113:1013-1023.*
9. *Vincent MO, Robinson EA, Latt L: Physicians as patients: Private psychiatric hospital experience. Can Med Assoc J 1969; 100:403-412.*
10. *Pond DA: Doctors' mental health. NZ Med J 1969; 69:131-135.*
11. *Small IF, Small JG, Assue CM, Moore DF: The fate of the mentally ill physician. Am J Psychiatry 1969; 125:1333-1342.*
12. *Franklin RA: One hundred doctors at the retreat. Br J Psychiatry 1977; 131:11-14.*
13. *Jones RE: A study of 100 physician psychiatric inpatients. Am J Psychiatry 1977; 134:1119-1123.*
14. *Bissel L, Jones RW: The alcoholic physician: A survey. Am J Psychiatry 1976; 133:1142-1146.*
15. *Jones RE: Mentally ill physicians. The Sciences, January 1979; pp. 19-21.*
16. *Murray RM: Characteristics and prognosis of alcoholic doctors. Br Med J 1976; 2:1537-1539.*
17. *Connelly JC: The alcoholic physician. J Kansas Med Soc 1978; 79:601-604.*
18. *Noble EP: Alcohol research quo vadis? Alcoholism Clinical and Experimental Research 1979; 3:93-94.*
19. *Report of the AMA Council on Mental Health: The sick physician: Impairment by psychiatric disorders, including alcoholism and drug dependence. JAMA 1972; 223:684-687.*
20. *Vaillant GE, Brighton JR, McArthur C: Physicians' use of mood-altering drugs: A 20 year follow up report. N Engl J Med 1969; 282:365-370.*
21. *Interview with H. J. Anslinger, the U.S. Commissioner of Narcotics. Modern Medicine 1957;25:170-191.*
22. *Green RC Jr, Carroll GJ, Buxton WD: Drug addiction among physicians: The Virginia experience. JAMA 1976; 236:1372-1375.*
23. *Putnam PL, Ellinwood EH Jr: Narcotic addiction amongst physicians: A ten year follow up. Am J Psychiatry 1966; 122:745-748.*
24. *Edwards G: The alcoholic doctor: A case of neglect. Lancet 1975; 2:1297-1298.*
25. *Sclare AB: Alcoholism in doctors. British Journal of Alcohol and Alcoholism 1979; 14:181-196.*
26. *Goby MJ, Bradley NJ, Bespalec DA: Physicians treated for alcoholism: A follow up study. Alcoholism Clinical and Experimental Research 1979; 3:121-124.*
27. *Wall LH: Results of hospital treatment of addicted physicians. Federation Bulletin 1958; 45:144-152.*
28. *Modlin HC, Montes A: Narcotic addiction in physicians. Am J Psychiatry 1964; 121:358-365.*